[1]*Mercer University, Atlanta, GA, USA,* [2]*All India Institute of Medical Sciences, New Delhi, India,* [3]*Sheri Kashmir Institute of Medical Sciences, Srinagar, India,* [4]*CDC, Atlanta, GA,* [5]*CDC India, New Delhi, India,* [6]*Inclen Trust Labs, New Delhi, India*

OBJECTIVES: Information on costs is critical to public health policy decision-making about prevention strategies, but is sparse in low-income countries. We conducted a prospective multi-site survey of persons hospitalized in public and private facilities with acute respiratory infection (ARI) in northern India to estimate the costs of ARI episodes. **METHODS:** Convenience samples of patients hospitalized with ARI were recruited at 9 public and 15 private health care facilities in the National Capital Region and Srinagar. Face-to-face surveys were conducted with participants upon admission to collect data on out-of-pocket costs of hospitalization, consultation, medications, diagnostics, transportation and lodging. Follow-up telephone surveys were conducted 2 weeks post-discharge to collect additional information including missed work and costs incurred after hospitalization. Out-of-pocket costs in public facilities were supplemented with WHO-CHOICE estimates. Missed worked days were valued on per capita national income (68,748 Indian Rupees). **RESULTS:** During September, 2012-March, 2013, 452 hospitalized ARI patients were enrolled (325 in public and 126 in private health facilities). Median total costs of hospitalized ARI in public facilities was 7,633 (IQR 4, 875-13,793) Indian Rupees (INR) [US$122 (IQR $78-221)] and in private facilities INR 13, 598 (IQR 8,993-22,924) [US$218 (IQR $144-367)]. The median length of stay was 7 days (IQR 5-11 days) in public facilities and 4 days (IQR 3-5) in private facilities. The indirect cost (defined as cost of missed work days) accounted for 16% of total cost in private facilities and 25% in public facilities. Median total cost of ARI for inpatients was 11% of annual per capita income in public institutions and 20% in private institutions. **CONCLUSIONS:** ARI episodes resulting in hospitalizations are expensive and could be higher if more than one episode occurs per year. The cost and benefit of proven strategies to reduce the burden, such as influenza and pneumococcal vaccination should be evaluated.

PHS34

ECONOMIC BURDEN OF URTICARIA REQUIRING HOSPITALIZATION: ANALYSIS FROM AN ADMINISTRATIVE DATABASE

Ciampichini R[1], Cozzolino P[1], Cortesi PA[2], Madotto F[2], Fornari C[2], Chiodini V[2], Mantovani LG[3], Cesana G[2]

[1]*Charta Foundation, Milan, Italy,* [2]*University of Milano – Bicocca, Monza, Italy,* [3]*Federico II University of Naples, Naples, Italy*

OBJECTIVES: Urticaria is a dermatological condition characterized by a vascular reaction of the upper dermis. The objective of this analysis was to assess the economic burden of urticaria from a large population based-study. **METHODS:** The study population was identified through the DENALI data warehouse of the Italian Lombardy Region: with a probabilistic linkage DENALI matches demographic, clinical and economic data of different Health care Administrative databases. We detected all subjects who were hospitalized for idiopathic urticaria (ICD-9 CM: 708.1) or other specified urticaria (ICD-9 CM: 708.8) during the period 2000–2011. The first hospital admission date was used as index date. We estimated health care costs (hospitalizations, drugs and outpatient examinations/visits) per patients-year from the National Health Service's perspective. **RESULTS:** During the study period, 7,864 subjects (63.2% female) experienced at least one hospital admission for idiopathic urticaria or other specified urticaria. Subjects had a median(min-max) age of 40.9(0.0-97.1); 35.4(0.1-97.1) and 42.4(0.0-97.1) years for idiopathic and other specified urticaria, respectively. The overall cost during the index year was around 2,100€/patient-years, with no significant differences between types of urticaria. From the 6th to the 1st year before the index event there was a slightly increase in costs: from 950€/patient-years to 1,400€/patient-years. The overall cost remained stable for the next 5 years after the event (1,200€/patient-years). Hospitalization represented the main driver of the overall cost: 61% before, 73% during, and 53% after the index event. The most prescribed therapies were antihistamines for systemic use, antibacterials and corticosteroids for systemic use, with a peak in the month of the index event; the prescriptions of corticosteroids as dermatological preparation were more frequent in the month preceding the hospitalization. **CONCLUSIONS:** The economic burden of urticaria was mainly attributable to the index hospitalization, which led to higher costs after the index event. Detailed analysis are allowed by administrative data.

PHS35

EPIDEMIOLOGIC AND ECONOMIC BURDEN ATTRIBUTABLE TO ATRIAL FIBRILLATION FROM ADMINISTRATIVE DATA

Ciampichini R[1], Cozzolino P[1], Cortesi PA[2], Fornari C[2], Madotto F[2], Chiodini V[2], Mantovani LG[3], Cesana G[2]

[1]*Charta Foundation, Milan, Italy,* [2]*University of Milano – Bicocca, Monza, Italy,* [3]*Federico II University of Naples, Naples, Italy*

OBJECTIVES: Atrial Fibrillation (AF) is the most common type of heart rhythm disorder, with a prevalence of 0.5% in the adult population. It causes a significant increase of cardiovascular complications and reduction of long-term survival. The objective of this analysis was to assess the epidemiologic and economic burden of AF from a large population based-study. **METHODS:** The study population was identified through the DENALI data warehouse of the Italian Lombardy Region: with a probabilistic linkage DENALI matches demographic, clinical and economic data of different Health care Administrative databases. The study population was made by all subjects who, during the period January 2000–December 2010, were hospitalized for AF and flutter (ICD-9-CM: 427.3) or received ablation of heart tissue (ICD-9-CM: 37.33 and 37.34) and/or conversion of cardiac rhythm (ICD-9-CM: 99.61,99.62, 99.69). The first hospital admission date was used as index date. We estimated incidence, mortality and health care costs (hospitalizations, drugs and outpatient examinations/visits) per patient-year from the National Health Service's perspective. **RESULTS:** During the study period, around 510,000 subjects (50.2% male) were detected, corresponding to 5 AF cases on 1,000 Lombardy inhabitants per year. Subjects had median(min-max) age of 74(0-110) years. According to the CHADS score, 62.8% and 15.6% of the study population had a moderate and high risk of stroke, respectively. The overall mortality rate (x100 person-years) was 9.9, increasing significantly with the increasing of CHADS score: 4.6, 8.9 and 18,5 for low, moderate and high stroke risk, respectively. The average cost during the index year was around 9,600€/patient-years: the main driver was represented by hospitalizations (83%), followed by drugs (9%). **CONCLUSIONS:** Administrative database analysis is an efficient tool to track epidemiologic and medical picture in patients with AF, which poses a significant burden in term of incidence, mortality and costs.

PHS36

COSTS OF PNEUMOCOCCAL DISEASES FOR CHILDREN UNDER 5 YEARS IN COLOMBIA

Diaz JA[1], Urrego Novoa JR[1], Moreno JA[2], Peralta Pizza F[3], Reyes Sanchez JM[3], Brown P[4]

[1]*Facultad de Ciencias, Universidad Nacional de Colombia, Bogotá, Colombia,* [2]*Universidad Distrital, Bogota, Colombia,* [3]*Universidad Nacional de Colombia, Bogotá, Colombia,* [4]*University of California, CA, USA*

OBJECTIVES: The most common infections due *Streptococcus pneumoniae* are: otitis, Pneumonia, meningitis and sepsis. The aim of this study was to estimate the direct and indirect costs of pneumococcal diseases, in population under 5 years old in Colombia. **METHODS:** Direct costs were determined from 2 sources: costs information for 2012 from a Health Medical Organization (HMO) with national coverage and the construction of cases-type based on clinical practice guidelines, through *bottom-up* methodology: the generating cost events were identified, validated with medical experts and valued according to tariff manual SOAT 2013. Indirect costs were related to mortality and sequelae caused by pneumococcal diseases. Mortality was estimated in terms of years of potential life lost (YPLL) based on the YPLLipc model (Gardner and Sanborn). Sequelae were measured in life years saved: disability-adjusted life years and the years of life lost to premature death. The cost estimation was done from the perspective of third-party payer. Costs were expressed in 2013 Colombian pesos (~1927 Colombian Peso per 1 USD). **RESULTS:** Taking into account the HMO information, the average cost of medical attention for Acute Otitis Media was $150,274 per outpatient case and $1,514,030 per inpatient case, for pneumonia $201,969 per outpatient case and $2,238,235 per inpatient case, for meningitis and sepsis $371,006 per outpatient case and $7,446,978 per inpatient case, for hearing loss $821,857 and for mastoiditis $206,473. Taking into account the cases-type information, the average cost of medical attention for Acute Otitis Media was $109,386 per initial case and $890,296 per recurrent case, for pneumonia $569,643 per mild case and $4,310,895 per severe case, for meningitis and sepsis $10,792,183 per case, for hearing loss $1,323,775 and for mastoiditis $535,692. The costs of YPLL were $12,014,669. **CONCLUSIONS:** Pneumococcal diseases cause a high economic impact on public health resources, due the incidence of diseases.

PHS37

COSTS OF PSYCHIATRIC ASSISTANCE (PA) IN A BRAZILIAN HEALTH CARE PLAN (HP): A REAL WORLD DATA ANALYSIS

Viana ADJR [1], Lopes AF[1], Matias CP[1], Moreira VP[1], Viana JL[1], ClarkOAC [2], Nishikawa AM[2]

[1]*Unimed Fortaleza, Fortaleza, Brazil,* [2]*Evidências, Campinas, Brazil*

OBJECTIVES: PA costs have increased during the last years, due to an increment in the number of affected patients. Our goal was to establish the profile and costs of PA in a health care plan in Brazil. **METHODS:** We searched the HP database in order to identify patients with psychiatric conditions. This HP has 364 000 users. We identified 569 patients that received psychiatric care during a 22-month period (January 2012-0ctober 2013). For each patient, we identified the resources used and the costs associated to them. **RESULTS:** Psychiatric care was responsible for 3.3% of all medical consultations performed in the HP and 4,955 hospitalizations, with a total cost of R$ 3 753 000 (US$ 1 563 000) (mean cost of R$ 4 560 (US$ 2 041) per patient). The most common diagnoses were substance abuse (ICD codes F10 to F19) and schizophrenia (ICD F20). Ancillary fees were responsible for 94% of total costs. Medications represented 7% of them. Antipsychotics drugs were responsible for 60% of the medication costs. **CONCLUSIONS:** PA is associated with a high cost in Brazil. Most costs are due to hospital fees.

PHS38

COST BURDEN OF CHRONIC PAIN IN A LARGE INTEGRATED DELIVERY SYSTEM IN THE UNITED STATES

Lamerato L[1], Dryer R[1], Mardekian J[2], Hegeman-Dingle R[2], Park PW[2], Zlateva G[2]

[1]*Henry Ford Health System, Detroit, MI, USA,* [2]*Pfizer, Inc., New York, NY, USA*

OBJECTIVES: Chronic pain is common and persistent in the population with over a third of US adults affected, many with disability and quality of life issues. Pain management is a substantial cost burden to the health care system We sought to determine the prevalence and burden of pain within a large integrated health care delivery system in the US. **METHODS:** Administrative databases pertaining to Henry Ford Health Systems (HFHS) patients were used to identify a cohort of adult persons with one or more of 25 pain conditions of interest in 2010 using ICD-9-CM diagnosis codes. Chronic pain was defined as at least two physician encounters at least 30 days apart. Data on prescription drug usage, hospitalizations, emergency room visits, physician encounters and total costs of care were obtained for a period of one year prior through one year after the index encounter for pain in 2010 to characterize resource utilization. Analyses were performed using SPS V 19.0. **RESULTS:** 44% of persons enrolled in the health plan had at least one pain encounter with 14% meeting the defined criteria for chronic pain. The conditions with the highest prevalence were joint pain, limb pain, and back pain. The study population also had a high prevalence of non-pain conditions including diabetes, chronic pulmonary disease, and renal disease. The overall medical costs for the patients with prevalent chronic pain conditions increased 24% in the post-period (average $22,639 vs. $31,692). The most costly conditions included diabetic neuropathy and multiple sclerosis and the greatest cost increases were observed for neuralgia, gout, and abdominal pain. Significant cost drivers included older age, presence of multiple comorbidities, and low body mass index. **CONCLUSIONS:** Chronic pain was a relatively frequent reason for health care service provision in HFHS and is associated with significant year-on-year increase in medical costs.

PHS39

DIRECT MEDICAL COST OF COMPLICATIONS IN PATIENTS WITH NON VALVULAR ATRIAL FIBRILLATION AT THE SOCIAL SECURITY IN PERU

Sanabria C[1], Cabrejos J[1], Guevara C[2], Olortegui A[2], Garrido Lecca S[3]
[1]Universidad Nacional Mayor de San Marcos, Lima, Peru, [2]Instituto Nacional Cardiovascular (INCOR) del Seguro Social de Salud del Perú, Lima, Peru, [3]Bristol-Myers Squibb, Lima, Peru

OBJECTIVES: Estimate direct medical costs of selected acute complications in patients with non-valvular atrial fibrillation (NVAF) at the Social Security (EsSalud) in Peru. **METHODS:** The electronic database of EsSalud´s reference hospital: Hospital Nacional Guillermo Almenara Irigoyen (HNGAI) was used to identify the study population. International Classification of Diseases (ICD) 10 codes were used to identify patients with NVAF and select complications of AF. Complications of interest are: ischemic stroke, hemorrhagic stroke, systemic embolism and myocardial infarction. Stroke events were classified by severity as mild, moderate, severe or fatal. All cases from 2011 -2012 meeting the inclusion criteria were reviewed. Patient level data from clinical charts was extracted to estimate resource utilization per patient per event. Costs were estimated using EsSalud´s 2013 tariffs manual and expressed per patient in 2013 USD. **RESULTS:** Ischemic stroke costs were estimated at $1,259, $1,818, $ 4,910, and $2,829.19 for mild, moderate, severe and fatal events, respectively. Hemmorhagic stroke were estimated at $1,707, $2,419, $11,991 and $2,111 for mild, moderate, severe and fatal event, respectively. Systemic embolism and myocardial infarction were estimated to cost $1,707 and $1,703 respectively. **CONCLUSIONS:** For AF patients within EsSalud, hemorrhagic stroke costs are higher than those estimated for ischemic stroke. As expected, costs increase as the severity of the event increase. These cost estimates can be used as patient-level costs inputs for economic model analysis of AF and its complications, from the perspective of EsSalud in Peru.

PHS40

HEALTH CARE PATHWAY AND COST OF OSTEOPOROSIS IN AN ITALIAN POPULATION

De Rosa M[1], Cinconze E[2], Rossini M[3], Rossi E[1], Adami S[3]
[1]CINECA Interuniversity Consortium, Casalecchio di Reno, Italy, [2]CINECA Interuniversity Consortium, Casalecchio di Reno , BO, Italy, [3]Rheumatology Unit, Dpt Medicine, University of Verona, Verona, Italy

OBJECTIVES: To describe Health Care Pathway and cost evaluation of patients with osteoporosis. **METHODS:** From ARNO Observatory, an Italian population database which provides comprehensive data referred to patient as: drug prescription, hospital discharges, imaging, lab tests and diagnostic examination, we analyzed a cohort of 185.489 subjects with osteoporosis in year 2011. A group without osteoporosis, matched by age, gender and LHU was compared to estimate differences in health costs and burden of disease. **RESULTS:** On a population of 5,313,167 over 40 years, we identified 185,489 patients treated with osteoporosis drugs (prevalence 3.5%). Prevalence rate is higher in female than male (6.1% vs 0.1%), modal value on 70-79 years. The average yearly cost/patient is 2.329€, 53% more than pair-matched group. This cost is due for 38.4% to drugs (31% specific drugs, 69% others), 42.8% to hospitalization and 18.8% to lab tests and diagnostic examinations. Most common specific drugs are bisphosphonates (81%), strontium ranelatum (21%), parathyroid hormone (1.2%) and SERMs (0.9%). A considerable percentage (24.8%) did not received vitamin D supplements in association. Compared to control group, patients with osteoporosis received more drugs expression of higher comorbidity (corticosteroids +70%, nervous system drugs +42%, PPI +33%) and were more frequently hospitalized, beyond fractures, for arthritis (+99%, p<0.01) and chronic bronchitis (+52%, p<0.01). Less than 50% of patients controlled their serum calcium levels in the last three years, 32% performed a densitometry and less than a fifth a radiography. **CONCLUSIONS:** A big data infrastructure is a valid instrument to evaluate patient care pathways, monitor the good practice of treatment and estimate cost of illness. In a large community setting of osteoporotic patients, the lack of supplement of vitamin D undermines the effectiveness of the specific pharmacological treatment. Despite low diagnostic approach, patients cost as much to the National Health System especially due to their frequent co-morbidities.

PHS41

ECONOMIC IMPACT OF RHEUMATIC DISEASES IN MEXICO

Arreola-Ornelas H[1], Camacho-Cordero LM[2], Dorantes-Aguilar J[1], Lemus-Carmona E[3]
[1]Fundación Mexicana para la Salud AC, Mexico City, Mexico, [2]Health Consoultings, Mexico City, Mexico, [3]Novartis Pharmaceuticals Corporation, Mexico City, Mexico

OBJECTIVES: Juvenile Idiopathic Arthritis (JIA), Ankylosing Spondylitis (AS), and Psoriatic Arthritis (PA) are rheumatic diseases which destroy articulations and limit their functions. The evolution of these conditions cause important physical impairment, which leads to disability, work loss, self-sufficiency, and QoL deterioration, among others. The objective is to estimate the economic impact of three rheumatic diseases: Juvenile Idiopathic Arthritis, Ankylosing Spondylitis, and Psoriatic Arthritis during 2011 using registries of the main Social Security Institution in the country called Instituto Mexicano del Seguro Social (IMSS). **METHODS:** It was review all registries related to the indications mentioned at different settings of care: ambulatory visits to GP and specialist, emergency room (ER), and hospital discharge (HD) of IMSS from January 1st to December 31st, 2011. Based on this information it was calculated the cost of care using unitary cost published by the Institution according to the type of service and the hospital DRG implicated. **RESULTS:** In 2011 the IMSS provided 45,528 consultations for AS, 51% were for patients between 30-49 years-old. 28,716 (63%) were for GP; 16,257 (36%) specialist; 555 (1%) ER, and 91 HD. For JIA, there were 6,285 consultations; 1,766 (28%) were for GP; 4326 (69%) for specialist; 193 (3%) ER, and 103 HD. For PA there were 1,587 consultations; 619 (39%) for GP; 873 (55%) specialist; 95 (6%) ER, and 195 HD. The costs of the three diseases at IMSS during 2011 were: AS = US $2.94 million, JIA =US $0.68 million and PA= US $0.37 million. The total cost of the three was US $4 millions (ER 1US=13MXN). **CONCLUSIONS:** These diseases affect quality of life and ability to work, considerably. Therefore, the cost of the three diseases might be underestimated due to productivity loss which is not included in the cost.

PHS42

INCREMENTAL HEALTH CARE RESOURCE UTILIZATION ASSOCIATED WITH AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE BY END-STAGE RENAL DISEASE STATUS

Iyer NN[1], Vendetti NJ[2], Levy DI[2], Mardekian J[3], Mychaskiw MA[2], Thomas III J[1]
[1]Purdue University, College of Pharmacy and Regenstrief Center for Healthcare Engineering, Center for Health Outcomes Research and Policy, West Lafayette, IN, USA, [2]Pfizer Inc., Collegeville, PA, USA, [3]Pfizer, Inc., New York, NY, USA

OBJECTIVES: Incremental health care resource utilization associated with autosomal dominant polycystic kidney disease (ADPKD) was estimated across two subgroups; individuals with ADPKD and end-stage renal disease (ESRD) and those with ADPKD but without ESRD. **METHODS:** Study data were from a large administrative claims and enrollment database. Individuals 18 y/o or older, enrolled in tracked health plans for 12 months from April 1, 2011 through March 31, 2012, and with an ICD-9-CM diagnosis code for "polycystic kidney, autosomal dominant" (753.13) or for "polycystic kidney, unspecified type (753.12) were identified as having ADPKD, and linked one-to-one with individuals without ADPKD on age and gender. ESRD was identified by presence of ICD-9-CM code 585.6. Zero-inflated negative binomial models estimated incremental hospitalizations, hospital days, outpatient visits, and emergency room visits for each sub-group, adjusting for age, gender, Charlson co-morbidity index, cardiovascular disease, diabetes and geographical region. **RESULTS:** A total of 3,844 individuals with ADPKD who satisfied selection criteria were linked one-to-one with 3,844 individuals without ADPKD. Among persons with ADPKD, 644 had a diagnosis of ESRD. The sample was 53% female and 55% were between 45 to 64 years old. Incremental mean (standard error) resource utilization associated with ADPKD with ESRD as compared to persons without ADPKD was 0.35 (0.052) or 35 additional hospitalizations per 100 patients, 2.5 (0.42) or 250 hospital days per 100 patients, and 24.0 (1.2) or 2,400 outpatient visits per 100 patients. Incremental mean (standard error) resource utilization associated with ADPKD but without ESRD as compared to persons without ADPKD was 0.065 (0.028) or 6.5 additional hospitalizations per 100 patients, 0.5 (0.091) or 50 hospital days per 100 patients, and 4.4 (0.41) or 440 outpatient visits per 100 patients. **CONCLUSIONS:** ADPKD was associated with incrementally greater health care resource utilization even before patients reached ESRD.

PHS43

TREATMENT PATTERNS AND COST OF CARE FOR PATIENTS WITH PANCREATIC CANCER

Seal BS[1], Xia F[1], Rietschel P[1], Germino R[1], Asche C[2], D'Souza AO[3], Morland K[3], Eaddy M[3]
[1]Bayer HealthCare Pharmaceuticals Inc., Whippany, NJ, USA, [2]University of Illinois, Peoria, IL, USA, [3]Xcenda, Palm Harbor, FL, USA

OBJECTIVES: This study evaluated treatment patterns and costs among patients with pancreatic cancer (PC). **METHODS:** A retrospective study analyzed data spanning January 2008-June 2012 from 3 large integrated claims databases. Adult patients with a diagnosis of PC (ICD-9 157.xx) were included if they had a minimum eligibility of 12 months prior and 3 months following their first PC diagnosis and had no diagnosis of cancer in the pre-period. Patients were categorized as having exocrine PC (ICD-9 157.0-157.3; 157.8-157.9), endocrine PC (ICD-9 157.4), or metastatic-exocrine PC (ICD-9 157.0-157.3; 157.8-157.9, 196.xx-199.xx). Treatment patterns, health care resource use, and all-cause costs (2012 USD) were evaluated after cancer diagnosis. **RESULTS:** There were 2901, 6119, and 464 patients in each of the 3 databases meeting all inclusion criteria, respectively. The majority of patients had exocrine PC (97%-98%), with 40%-76% having metastatic disease. Patients were on average 60.3-64.5 (±11.3-14.0) years of age and 43%-52% were female. No treatment was received by 35%-55% of patients, 36%-55% of patients received chemotherapy ± radiation and/or surgery, and 9%-10% received radiation and/or surgery without chemotherapy. Second and third-line chemotherapy was received by 17%-32% and 9%-17% of patients, respectively. Among those with exocrine PC, patients with metastatic disease experienced an average of 0.25-0.31 inpatient, 2.3-2.9 office, 3.0-4.0 other outpatient visits and received 4.2-5.1 prescriptions per month vs 0.09-0.11 inpatient visits, 1.3-1.7 office visits, 1.3-1.9 other outpatient visits and 3.2-4.1 prescriptions per month in those without metastatic disease. Total monthly costs averaged $9,478-$12,042 and $1,022-$3,084 in patients with and without metastatic disease, respectively. The majority of costs were attributable to medical services ($7,977-$11,212 and $697-$2,852, respectively), with pharmacy costs contributing to a small proportion of the total costs ($830-$1,501 and $232-$326, respectively). **CONCLUSIONS:** Health care resource utilization and costs are highest among those with metastatic PC, totaling as much as $12,042 per month.

PHS44

COST OF PATIENT CARE AT DIFFERENT STAGES OF TREATMENT WITHIN THE PUBLIC HEALTH MODEL OF HIV CARE; ANALYSIS FROM AN URBAN HIV CENTRE IN UGANDA

Parkes-Ratanshi RM[1], Kakaire T[1], Sempa J[1], Musiime B[1], Castelnuovo B[1], Kuznik A[2], Schlech W[3]
[1]Infectious Diseases Institute, Kampala, Uganda, [2]Celgene Corporation, Summit, NJ, USA, [3]Dalhousie University, Halifax, Canada

OBJECTIVES: In 2013 a change in WHO guidelines increased the number of people recommended to start antiretroviral treatment (ARVs) from 16 to 28 million worldwide; at present around 10 million are enrolled in care. Additionally the number of people requiring second line antiretrovirals (ARVs) is increasing. Much of this burden is in Sub Saharan Africa (SSA). The Infectious Diseases Institute (IDI) in Kampala, Uganda runs a clinic of 8000 patients; some of these have been on ARVs for >10 years. The objective of this study was to analyze actual costs of different patient subgroups per year at IDI. **METHODS:** We use a fully digitalized electronic patient management system (ICEA), which records individual patient data including all visit information. We linked ICEA to Navision accountancy software, in order to determine the actual cost of patient care from October 2012-October 2013. The analysis was conducted from a provider perspective. We calculated the average cost